

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01568

## 1587 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Prince Frederick</u>		<u>14 hrs</u>		TOWN <u>Barstow</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (if rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>John Boot</u>				4. DATE OF DEATH (Month) <u>2</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>	8. DATE OF BIRTH <u>Jan. 15 1956</u>	9. AGE last birthday <u>2</u> yrs.	IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Julius Boot</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Owen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Bertha Owen, Barstow</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
772.0 IMMEDIATE CAUSE (A) <u>MALNUTRITION</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>—</u>							
(C) <u>—</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 6, 1956</u> to <u>Feb 7, 1956</u> , that I last saw the deceased alive on <u>Feb 7, 1956</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>P. E. Sewell</u> M.D.				ADDRESS (Street, city, town, state) <u>Barstow Md</u>		DATE SIGNED <u>2/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Carroll</u>		LOCATION (City, town, or county) <u>Barstow Md</u>	
24. REC'D BY REGISTRAR DATE <u>2-9-56</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Prince Fred, Md</u>	

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RECEIVED

FEB 10 1956

BUREAU V. S.

# DEATH CERTIFICATE

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

101001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1588

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01569

Reg. Dist.

No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cabaret</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Cabaret</u>	
CITY (If outside corporate limits write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Prince Frederick</u>				TOWN <u>Prince Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Frank</u>		(Middle) <u>Brightwell</u>		(Last) <u>Brightwell</u>		5. DATE (Month) (Day) (Year) <u>2</u> <u>17</u> <u>1956</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>Feb. 11, 1910</u>	
9. AGE last birthday: <u>46</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Cabaret County, Ind</u>		11. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Taxi Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Taxiing</u>			
13. FATHER'S NAME: <u>Frank Brightwell</u>				14. MOTHER'S MAIDEN NAME: <u>Ada Fowler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>3</u>		17. INFORMANT & ADDRESS: <u>Mr. Frank Brightwell - Prince Frederick, Ind.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>gunshot wound of chest</u> DUE TO <u>Had been missing for 3 days</u> (b) Antecedent cause(s) <u>Had been missing for 3 days</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>Had been missing for 3 days</u> (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Found dead in car in woods</u>							
19a. DATE OF OPERATION: <u>Feb. 21, 1956</u>				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE OF INJURY: <u>Home</u>		21c. (City or town) <u>Prince Frederick</u>		(County) <u>Ind</u> (State) <u>Ind</u>	
21d. TIME (Month) (Day) (Year) (Hour) (Minute) <u>Feb 21/1956 8P</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>gun shot wound of chest</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <u>H. W. Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/19/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL, (Specify): <u>Burial</u>		DATE THEREOF: <u>Feb. 21, 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>Wesley Cemetery</u>		LOCATION (City, town, or county) (State): <u>Prince Frederick Cabaret Co, Ind.</u>	
DATE REC'D BY LOCAL REG. <u>2-20-56</u>		REGISTRAR'S SIGNATURE: <u>H. W. Ward</u>		24. FUNERAL DIRECTOR: <u>G. G. Warkness &amp; Son - Mutual, Ind.</u>		ADDRESS	

BUREAU V. S.

FEB 23 1956

RECEIVED

## 1589 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lusby</u>				TOWN <u>Lusby</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Amanda</u>		(Middle)		(Last) <u>Commodore</u>		(Month) <u>2</u> (Day) <u>13</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct. 1</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Andrew Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>David Commodore Lusby, Md</u>			
		(If Yes, give war or dates of service)					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cornary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>(Heart failure)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension c.v.d x. general atherosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>56</u> , to <u>2/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/13</u> , 19 <u>56</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. Williams</u> M.D.				ADDRESS (Street, city, town, state) <u>St. Johns</u>		DATE SIGNED <u>2/18/56</u>	
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		LOCATION (City, town, or county) (State) <u>Lusby Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Jr., Fred, Md</u>		ADDRESS	
DATE <u>2-11-56</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

12-1 CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF CORONER

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CONSTABLE

18. SIGNATURE OF TOWNSHIP CLERK

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF STATE CLERK

BUREAU V. 3

FEB 15 1956

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FEB 15 1956  
BUREAU V. 3



**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01571

1590

# CERTIFICATE OF DEATH

Reg. Dist. No. 51

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Calvert</u>		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Prince Frederick</u>		<u>21 days</u>		TOWN <u>Prince Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Ferdinand Lyles Freeland</u>				<u>February 2 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>white</u>	<u>married</u>	<u>April 9, 1873</u>	<u>82</u> yrs.	Months <u>9</u> Days <u>63</u>	Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>farmer</u>		<u>retired</u>		<u>Maryland</u>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>George T. Freeland</u>				<u>Wilmina Lyons</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>No</u>		<u>Mrs. Lillie Freeland - Prince Frederick</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u></u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arterio-sclerosis</u></u>							
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>acidosis</u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan 26 1956</u>, to <u>Feb 2 1956</u>, that I last saw the deceased alive on <u>Feb 2 1956</u>, and that death occurred at <u>8:50A.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Dr. William S. St. Leonard</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>St Leonard</u> <b>DATE SIGNED</b> <u>2/2/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Feb. 4, 1956</u>		<u>St. Paul's Cemetery</u>		<u>Prince Frederick, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>DATE 2-6-56</u>		<u>H. W. Ward</u>		<u>A. A. Haskins &amp; Son - Mutual, Ind.</u>			

# CERTIFICATE OF DEATH

500

When Filled In

A. Name of deceased (Print name and full name)

B. Sex

C. Date of birth

D. Place of birth

E. Date of death

F. Cause of death

G. Place of death

H. Name of physician

I. Name of funeral director

J. Name of undertaker

K. Name of hospital

L. Name of nursing home

M. Name of cemetery

N. Name of church

O. Name of family

P. Name of friends

Q. Name of neighbors

R. Name of community

S. Name of school

T. Name of business

U. Name of occupation

V. Name of profession

W. Name of religion

X. Name of race

Y. Name of color

Z. Name of nationality

BUREAU V. S.

FEB 7 1956

RECEIVED

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1591

01572  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 51

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits write RURAL OR and give nearest town) TOWN <u>Island Creek</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Island Creek</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <u>Melvin</u> (First) <u>Raye</u> (Middle) <u>Forman</u> (Last)		4. DATE OF DEATH <u>2</u> (Month) <u>5</u> (Day) 19 <u>56</u> (Year)	
5. SEX: <u>7</u>	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>July 14 1954</u>
		9. AGE last birthday: <u>1</u> yrs. <u>10</u> Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min.	10. IF UNDER 1 YEAR
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Wash DC</u>
13. FATHER'S NAME: <u>Melvin Forman</u>		14. MOTHER'S MAIDEN NAME: <u>Elise S. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>Melvin Smith, Island Creek, MD</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  Immediate cause (a) <u>Pneumonia</u> DUE TO Antecedent cause(s) (b) <u>Found dead in bed at 1030 PM</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H. Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/2/56</u> DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF <u>2-6-56</u>	NAME OF CEMETERY OR CREMATORY <u>mt Hope</u>	LOCATION (City, town, or county) (State) <u>Seaboard</u> <u>md</u>
DATE REC'D BY LOCAL REG: <u>2-6-56</u>	REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	24. FUNERAL DIRECTOR <u>P. E. Seawell</u> ADDRESS <u>Prince Fred</u>	

BUREAU V. S.

FEB 7 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1592

## CERTIFICATE OF DEATH

01573

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE HOME OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Prince Fred.</u>		<u>19</u>		TOWN <u>Queen's</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>County Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Lula</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2-29-1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
						9. AGE last birthday <u>44</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Wesley Jones.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kent</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>William Gross. Queen's Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Neuron Stage</u>						<u>2/7/56</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/12</u> , 19 <u>56</u> , to <u>2/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>56</u> , and that death occurred at <u>2</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Page 1-7</u>		M.D. <u>Prince Frederick</u>		ADDRESS (Street, city, town, state) <u>Calvert Co., Md</u>		DATE SIGNED <u>2/29/56</u>	
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Edmunds</u>		LOCATION (City, town, or county) (State) <u>Calvert Co., Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Jewell</u>		ADDRESS <u>Prince Fred. Md</u>	
DATE <u>2-29-56</u>							

U. S. AIR MAIL

MAR 1 1956

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1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01574

## 1593 CERTIFICATE OF DEATH

Reg. Dist. No. 51

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Island Creek</u>				TOWN <u>Island Creek</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>E. E. E. Johnson</u>				<u>2 19 56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>F</u>	<u>C</u>		<u>Oct 16,</u>	<u>82</u> yrs.	Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Domestic</u>				<u>Maryland</u>		<u>U.S.A</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Nelson Sanders</u>				<u>Florence Gantt</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<u>James Johnson, Island Creek.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X IMMEDIATE CAUSE</b> (A) <u>Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Hypertension and cerebral</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b> (C) <u>Hemorrhage</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>7:10</u> to <u>11:19</u>, 19<u>56</u>, that I last saw the deceased alive on <u>5-18-56</u>, and that death occurred at <u>5:18</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>R. Williams</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>St. Thomas</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
				<u>2-22-56</u>		<u>Brookside</u>	
						<u>Island Creek Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
DATE <u>2-20-56</u>		<u>H. W. Ward</u>		<u>P. E. Sewell, Prince Frederick, Md</u>			

BOHEAU K.

FEB 21

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1594

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cabot</i>		MARYLAND		STATE <i>Ind</i>		COUNTY <i>Cabot</i>	
CITY (If outside corporate limits, write RURAL or give nearest town) <i>Prince Frederick</i>		LENGTH OF STAY (in this place) <i>7 mos.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>St. Leonard</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Cabot County Hosp.</i>				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Jennie M. Lyons</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Feb. 1, 1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>Mar. 13, 1877</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR Months <i>10</i> Days <i>18</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Dorchester Co., Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Thomas Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Brahan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i> (If Yes, give year or dates of service)			16. SOCIAL SECURITY NO. <i>720</i>	17. INFORMANT & ADDRESS <i>St. Leonard</i> <i>Miss Mary E. Williams</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Acidosis</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Diabetes Mellitus</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Exhaustion</i>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>July 1955</i>		19b. MAJOR FINDINGS OF OPERATION <i>Chronic right lung</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1-3, 1956</i> , 19 <i>55</i> , to <i>2-1</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1-3</i> , 19 <i>56</i> , and that death occurred at <i>St. Leonard</i> M., from the causes and on the date stated above							
SIGNATURE <i>R. Williams</i>				ADDRESS (Street, city, town, state) <i>St. Leonard</i>		DATE SIGNED <i>1/2/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Feb. 3, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>St. Leonard Cemetery</i>		LOCATION (City, town, or county) <i>Huntingtown, Ind</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness &amp; Son - Mutual, Ind</i>		ADDRESS	
DATE <i>2-2-56</i>							

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 12 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



## 1595 CERTIFICATE OF DEATH

Reg. Dist. No. 51

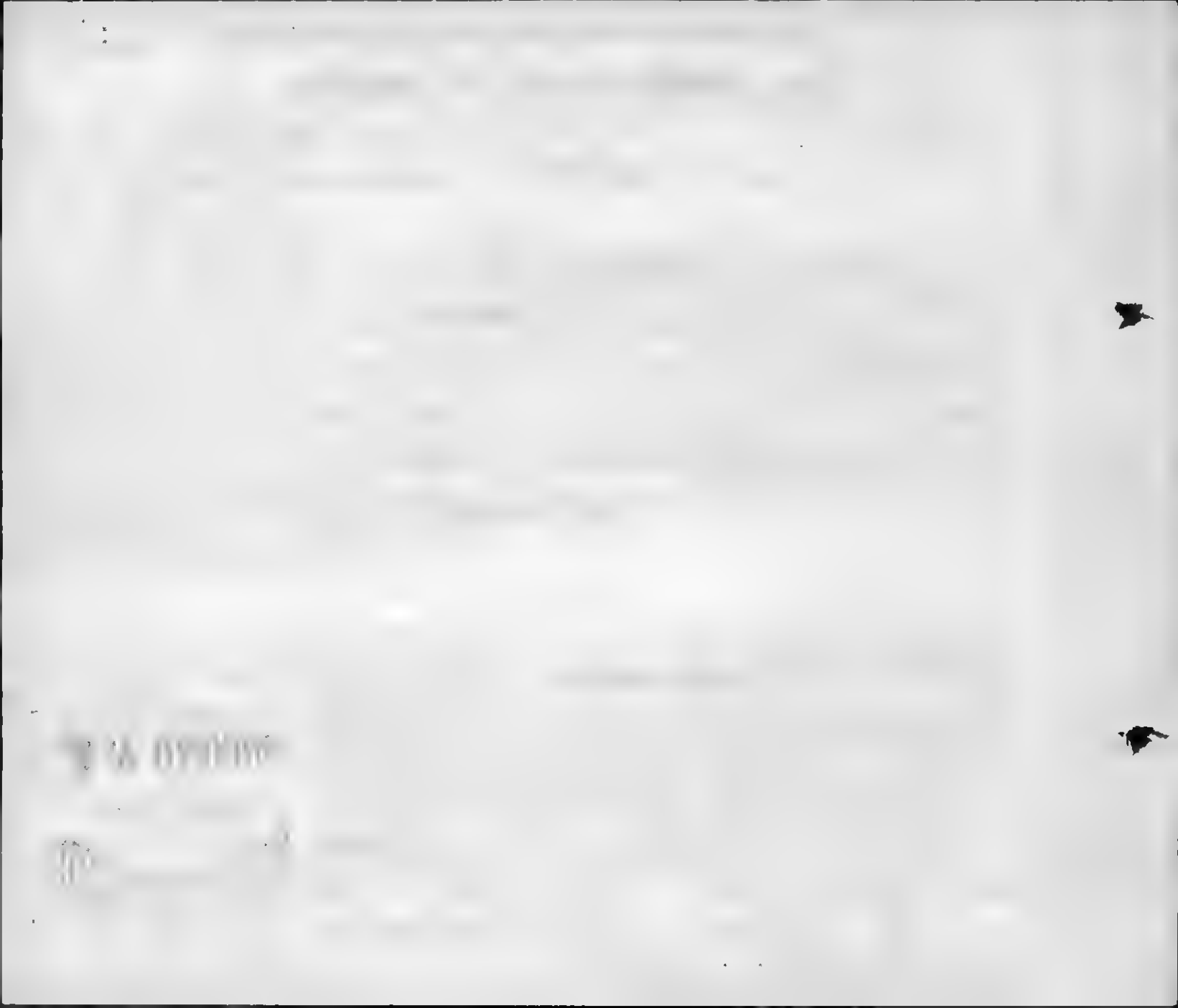
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Prince Frederick</u>				TOWN <u>Olivet</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Baby Girl Mackall</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 3 1956</u>			
5. SEX <u>Female</u>	6. CO. OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>February 2 1956</u>	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prince Frederick Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Hilton Mackall</u>				14. MOTHER'S MAIDEN NAME <u>Jean Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Stan Mackall, 9105 1st St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Premature</u>				<u>(6 1/2 months)</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 2</u> , 19 <u>56</u> , to <u>Feb 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 3</u> , 19 <u>56</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edmund</u>		M.D. <u>ST LEONARD</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>2/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>Private</u>		LOCATION (City, town, or county) (State) <u>Olivet, Calvert Co., Md.</u>	
24. REC'D BY REGISTRAR <u>H. W. Ward</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hilton Mackall - Clivet, Md.</u>		ADDRESS	

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104



**INSTRUCTIONS**  
**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01577

1596

# CERTIFICATE OF DEATH

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Huntingtown</u> <u>Calvert</u> <u>MARYLAND</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u> <u>LIFE</u>	STATE <u>md</u> COUNTY <u>Calvert</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<u>JOHN</u> <u>FRANKLIN</u> <u>NORFOLK</u>		<u>Feb. 2</u> <u>1956</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>
<u>M</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>JULY 13, 1871</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>9. AGE last birthday</b>
<u>FARMING</u>		<u>OWNER</u>	<u>84</u> yrs.
<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>HUNTINGTOWN, MD.</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
<u>THOMAS H. NORFOLK</u>		<u>ELIZABETH CROSS</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<u>NO</u>		<u>EDWARD NORFOLK, HUNTINGTOWN, MD.</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<input checked="" type="checkbox"/> IMMEDIATE CAUSE (A)		<u>Cerebral accident</u>	
ANTECEDENT CAUSE(S) DUE TO (B)		<u>Hypertension</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>1/18</u> , 19 <u>56</u> , to <u>2/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/1</u> , 19 <u>56</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above.			
<b>SIGNATURE</b>		<b>DATE SIGNED</b>	
<u>[Signature]</u>		<u>2/2/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<u>Buried Feb 5, 1956</u>		<u>St. Mirando</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<u>2/5/56</u>		<u>[Signature]</u>	
<b>REGISTRAR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>[Signature]</u>		<u>Huntingtown Md</u>	





1597

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bromes Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bromes Island</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>E.</u> Last <u>Rogers</u>				4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1862</u>		9. AGE (In years last birthday) <u>94</u> yrs		IF UNDER 1 YEAR: Months <u>1</u> Days <u>7</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cabaret County, Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Garner</u>				14. MOTHER'S MAIDEN NAME <u>Ann Elizabeth Ramsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Ballard Rogers - Bromes Island, Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1955</u> to <u>Feb. 21, 1956</u> , that I last saw the deceased alive on <u>Apr. 19, 1956</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Prince Frederick</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT, M.D.</u>				<u>PRINCE FREDERICK, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waters Memorial Cem. Island Creek - Cabaret Co - Ind</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness &amp; Son - Mutual, Ind</u>				24a. REC'D BY REGISTRAR DATE <u>2-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 weeks</u>		d. STREET ADDRESS <u>3513 Eather Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle _____ Last <u>Slitzer</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>9</u> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Sanders</u>		14. MOTHER'S MAIDEN NAME <u>Anna ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Serille Morgan - Prince Frederick, Md</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs 23</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4/6</u> 19 <u>56</u> , to <u>2/24</u> 19 <u>56</u> , that I last saw the deceased alive on <u>2/24</u> 19 <u>56</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u>		ADDRESS (Street, city or town, state) <u>Prince Frederick, Md</u>	
DATE SIGNED <u>2/25/56</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		<u>PRINCE FREDERICK, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cabarrus Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Md</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.A. Haskewood &amp; Son - Mutual, Md</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>H. W. Ward</u>		DATE <u>2-27-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01580

## 1599 CERTIFICATE OF DEATH

Reg. Dist. No. 41

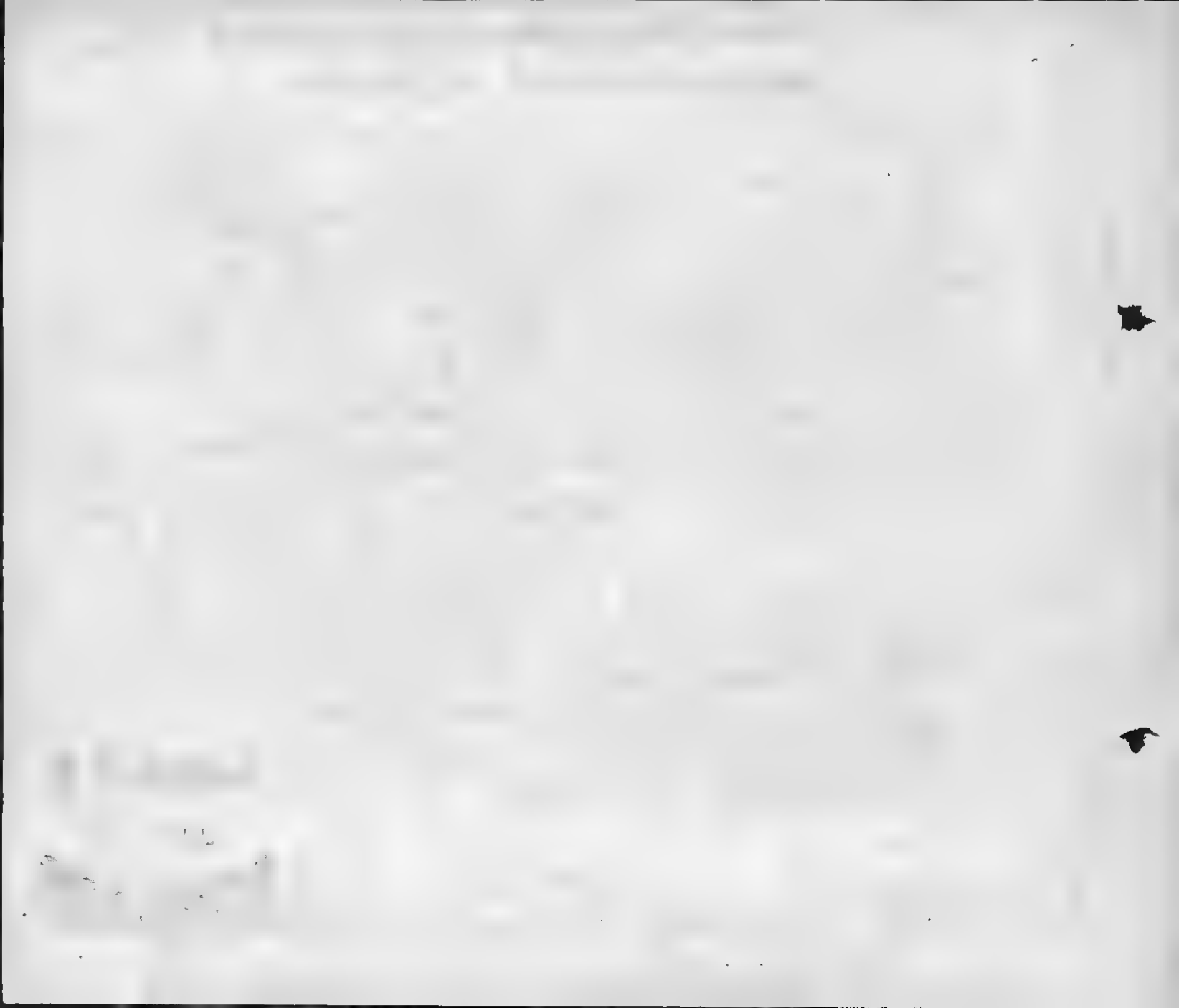
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Prince Frederick 4 days</u>		TOWN <u>Chesapeake Beach</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Calvert</u>		STREET ADDRESS (if rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>Smith</u>		<u>2/27</u> 19 <u>56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>February 23 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Bobby Lee Holland</u>		14. MOTHER'S MAIDEN NAME <u>Grecie Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
776X IMMEDIATE CAUSE (A) <u>Prematurity (6th month)</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>(weight 1-lb 12oz)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>2-27-56</u> , 19 <u>56</u> , to <u>2-28-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-27-56</u> , 19 <u>56</u> , and that death occurred at <u>3p</u> M., from the causes and on the date stated above.		22. HOW DID INJURY OCCUR?	
SIGNATURE <u>R. Williams</u> M.D.		ADDRESS (Street, city, town, state) <u>St. Edmonds</u> DATE SIGNED <u>2/27</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2-28-56</u>	
24. REC'D BY REGISTRAR <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bobby Lee Holland - Ches. Beach, Md.</u>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





## MARYLAND STATE DEPARTMENT OF HEALTH

01581

2411 N. Charles Street, Baltimore

1690

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH- COUNTY <u>Calver</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Lusby</u> COUNTY <u>Calver</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>	
TOWN <u>Lusby</u>		TOWN <u>Lusby</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lusby</u>		STREET ADDRESS (If rural, give location) <u>Lusby</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY</u> (First) <u>EVELYN</u> (Middle) <u>TORNEY</u> (Last)		4. DATE OF DEATH <u>Feb.</u> (Month) <u>9</u> (Day) <u>1956</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3/16/1908</u>
9. AGE last birthday <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lusby, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Gray</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Patterson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>James Edward Torney</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>8 hrs</u>
Antecedent cause(s) (b) <u>Periility -</u>		<u>3 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>✓</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>✓</u>	

22. I hereby certify that I attended the deceased from 12/16, 1955, to 7/9, 1956, that I last saw the deceased alive on 7/6, 1955, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE D.E. S. Coster ADDRESS Solomons, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>7/15/56</u>	NAME OF CEMETERY OR CREMATORY <u>St. John M.E.</u>	LOCATION (City, town, or county) <u>Lusby, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>7/9/56</u>		REGISTRAR'S SIGNATURE <u>D.E. S. Coster</u>		24. FUNERAL DIRECTOR <u>Pinkey Sewell, Prince Georges Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 15 1956

BUREAU V. S.

1601

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>L.</u> Last <u>Trott</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John H. Lyons</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hovew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Jackson Trott, Huntingtown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure &amp; Decompression</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V. disease</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> , to <u>Feb 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>56</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page Pratt</u> M.D.				ADDRESS (Street, city or town, state) <u>Prince Frederick</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>				DATE SIGNED <u>PRINCE FREDERICK, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 28 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Miranda Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness &amp; Son, Mutual Md.</u>				24a. REC'D BY REGISTRAR <u>H. W. Ward</u>		24b. REGISTRAR'S SIGNATURE <u>DATE 2-28-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

MAR 1 1956

RECEIVED